

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 0 — 2 4

2. STATE:

Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

October 1, 2000

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.253

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 224,584  
b. FFY 2002 \$ 224,584

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19D  
Part II  
Subpart 0  
Exhibit 0-1  
Pages 2 & 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 4.19D  
Part II  
Subpart 0  
Exhibit 0-1  
Pages 2 & 3

10. SUBJECT OF AMENDMENT:

Payment rates for non-state intermediate care facilities for the  
mentally retarded.

11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Secretary Schalansky is the  
Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Janet Schalansky

14. TITLE:

Secretary

15. DATE SUBMITTED:

12/27/00

16. RETURN TO:

Janet Schalansky, Secretary  
SRS  
6th Floor, DSOB  
915 SW Harrison  
Topeka, KS 66612

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

12/28/00

18. DATE APPROVED:

MAR 15 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

OCT 01 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Thomas W. Lenz

22. TITLE:

ARA for Medicaid and State Operations

23. REMARKS:

CC:  
Schalansky  
Haverkamp  
CO

SPA CONTROL

Date Submitted 12/27/00

Date Received 12/28/00

# KANSAS MEDICAID STATE PLAN

Attachment 4.19 D

Part II

Subpart O

Exhibit 0-1

Page 2

## II. Or, all other ICF's/MR (nonstate) (class 2)

### Levels of Care:

The level of functioning is calculated by screening all ICF/MR clients in Kansas using the Developmental Disabilities Profile (DDP), which rates clients on each of three indexes: adaptive functioning, maladaptive behavior, and health needs. Facility converted scores are obtained by performing the following calculations:

1. Each index score is divided by the highest score obtained in Kansas in a given year for the corresponding index.
2. The resulting scores for each index are added together and averaged.
3. The resulting number is multiplied by 100. (Thus, the maximum possible converted score is 300).

Using the above methodology, five levels of facilities are identified based on the following converted DDP scores:

<u>LEVELS</u>	<u>CONVERTED DDP SCORES</u>
Level I	150 - and up
Level II	125 - 149.99
Level III	100 - 124.99
Level IV	75 - 99.99
Level V	50 - 74.99

Direct service limits are based on facility size; divided into three groups: above 16 beds; 9 to 16 beds; and 4 to 8 beds; and level of functioning using the chart above.

	<u>Facility Size</u>	<u>Level I</u>	<u>Level II</u>	<u>Level III</u>	<u>Level IV</u>	<u>Level V</u>
A.	+16 beds	\$120.00	\$115.25	\$ 98.66	\$ 82.39	\$ 59.85
B.	9-16 beds	\$135.00	\$129.59	\$103.72	\$ 92.08	\$ 69.54
C.	4-8 beds	\$155.00	\$141.49	\$129.05	\$ 99.91	\$ 78.55

Administrative per diem limits are based on the size of the facility, using the same classes as referred to above.

MAR 15 2001

TN # MS-00-24 Approval Date \_\_\_\_\_ Effective Date 10/1/2000 Supersedes MS 97-14

## KANSAS MEDICAID STATE PLAN

Attachment 4.19 D

Part II

Subpart O

Exhibit 0-1

Page 3

A.	+16 beds	\$ 8.25
B.	9-16 beds	\$15.25
C.	4-8 beds	\$22.00

Ownership allowance is established by a property fee system, which is a continuation of the system used previously. The fee has been calculated by analyzing all facility costs, arranging them from high to low, placing them into five groups and adding "value factors":

### VALUE FACTOR

The per diem reimbursement for facility ownership is based on the historic cost of each facility. The value factor was to reward those with low ownership costs – mortgage interest, rent/lease expense, amortization and depreciation. The value factor calculations for ICFs/MR may be found below and are the same as used in the Nursing Facility program (see Medicaid State Plan transmittal #87-43, effective 10-1-87, approved 2-5-88).

#### **Calculation methodology for the value factor:**

##### 1) Property Allowance Calculation

The four line items of ownership cost—mortgage interest, rent/lease expense, amortization and depreciation—were added together and divided by client days to arrive at the ownership cost per client day for each provider.

##### 2) Value Factor Calculation

For all providers the property allowances were arrayed based on facility size and percentiles were established. These percentiles became the basis for establishing the property value factor. Five different percentile groupings were developed from each array as follows.

<u>Group No.</u>	<u>Percentile Ranking</u>	<u>Add-on Percent</u>
1	Zero through 25 <sup>th</sup> Percentile	45%
2	26 <sup>th</sup> through 50 <sup>th</sup> Percentile	15%
3	51 <sup>st</sup> through 75 <sup>th</sup> Percentile	7.5%
4	76 <sup>th</sup> through 85 <sup>th</sup> Percentile	5%
5	86 <sup>th</sup> through 100 <sup>th</sup> Percentile	-0-

**MAR 15 2001**

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**MAR 15 2001**